

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

SHEILA A. SHIMA
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director



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DEPARTMENT OF MENTAL HEALTH

<http://dmh.lacounty.gov>

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: (213) 738-4601
Fax: (213) 381-7092

May 31, 2007

TO: Each Supervisor

FROM: Marvin J. Southard, D.S.W.
Director of Mental Health

A handwritten signature in black ink, appearing to be "MJS", is written over the printed name of Marvin J. Southard.

SUBJECT: **TERMINATION OF COMMUNITY CARE RESIDENTIAL FACILITY
AGREEMENT WITH PORTALS HOUSE INC., DBA TWIN PEAKS DUAL
RECOVERY**

This memo is to advise your Board of the termination of the Community Care Residential Facility (CCRF) Agreement with Portals House Inc., dba Twin Peaks Dual Recovery Agreement Number MH-160013, effective June 30, 2007. This agreement is being terminated to implement a mutually agreed upon merger by and between Portals House Inc., and Pacific Clinics, anticipated merger effective July 1, 2007.

Board approval for this Community Care Residential Facility was given June 2, 2006, Agenda Item No. 51.

MJS:KW:RK:jg

Attachment

c: Executive Officer, Board of Supervisors
Chief Administrative Office
County Counsel
Sheila A. Shima
Jim Allen
Karalyn Wallensak
Mary Marx
Richard Kushi
Mike Motodani
Jaime E. Gonzalez

"To Enrich Lives Through Effective and Caring Service"

SERVICE REQUEST FORM

3057 TO
3044
PP/KPS

To: Richard Kushi, Acting Chief

Date:

5/7/07

Approved by:

Deputy Director

Paul McIver

Signature

Date:

Edward J. Vidaurri

Edward Vidaurri, LCSW

Requested by
Lead Manager:

Tel. No.:

(213) 738-3765

Approved by:

Office of the Finance Director

Signature

Date:

☐

No Budget Impact

☐

B.A. Required

Contact
Person:

Carol Giannini

Tel.
No.:

(213) 738-4963

☐

New Contract

Amendment

☐

RFP

☐

RFI

X Other

DELETION OF Legal Entity and All Provider Numbers

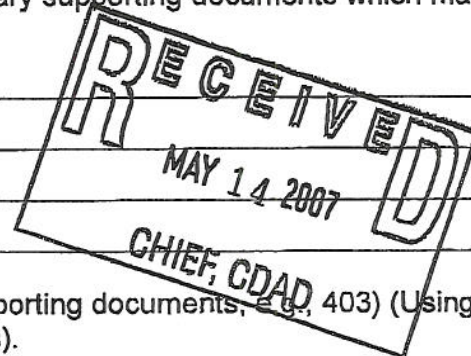
PROVIDER NUMBER Please see attached letter

I. PROVIDER NAME: Portals House Inc.

II. PROVIDER NO:

III. DESCRIPTION OF PROJECT (Please attach necessary supporting documents which may include appropriate negotiation package information).

Terminate Legal Entity and All Provider Numbers



IV. FUNDING SOURCES (Please attach necessary supporting documents, e.g., 403) (Using the most current Financial Summary, identify the revised areas).

N/A

NOTE: PFARS do not require Finance approval, however, Program approval is required.

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROVIDER FILE ADJUSTMENT REQUEST**

3043
TRACK#

Date: 5/7/07

TO: Roxanne Lockett
Chief Information Office Bureau

FROM: Edward Vidaurri, LCSW
Lead Manager or Program Chief/Manager

**For Contracts Development & Administration
Division Use Only**

No Contract
Action Required ☐

Action Required:

Amendment ☐ Agreement ☐

Initials & Date _____

Contact Person: Carol Giannini

Phone #: (213) 738-4963

Please update or add to the Provider File for the following provider (check one):

Provider of Record ☒ Request for New Provider ☐ (Must be accompanied by a completed MH3829 form.)

Child ☐ Adult ☒ Older Adult ☐ Critical Care/Adult Forensic ☐ Courts Programs ☐

Request for New Legal Entity ☐ (Must be accompanied by a completed MH 3840 form.)

Change of Ownership ☒ Head of Service Change ☐

This request is for a:

*Public

*Satellite Provider (less than 20 hrs/wk) ☐ School Site(s) ☐

School or School District Name

(*If School District, please attach a listing of all school sites where services are provided and identify if records are stored at the school site, and medication support, other than prescription).

SD/MC Certified Site: Not Currently Certified ☐ Currently Certified ☒ Initial Request ☐
(PSB will initiate SD/MC Certification.)

Provider Number: 7039 Reporting Unit: All FFS State Prov. Number: _____

Legal Entity Number: 00205 Legal Entity Name: Portals House, Inc.

Provider Name: Portals House - Twin Peaks

Provider Address: 255 S. Mariposa Ave., Los Angeles, Ca. 90004

Phone #: 213-639-2683 Fax #: () _____

Provider Director: Laurel Freeman LCSW

Current ☒ New ☐

MIS INFORMATION

Adjustment(s) Requested:	Add	Change	Delete	Specify Adjustment
1. Provider Number:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Terminate Legal Entity and All Provider Numbers
2. Provider Name:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Change: _____
*3. Provider Address:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	New Addr.: _____
4. Reporting Unit Number:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
5. Reporting Unit Name:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
*6. Reporting Unit Address:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	New Addr.: _____

*For SD/MC Providers, Department Program Staff must contact Program Support Bureau (Program Review) Bureau to ensure that all requirements have been met.

Provider Name

Portals House, Inc.

Provider Number

7039

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7. Add CR/DC Mode, Service Function Code (Attach a list, if additional space is needed.)

<u>MODE</u>	<u>SPECIFIC SFC</u>	<u>DESCRIPTION</u>	<u>PROGRAM/FUND SOURCE</u>

8. Inactive CR/DC Mode, Service Function Code (Attach a list, if additional space is needed.)

<u>MODE</u>	<u>SPECIFIC SFC</u>	<u>DESCRIPTION</u>	<u>PROGRAM/FUND SOURCE</u>
ALL	ALL		

9. New SD/MC Mode

05 Residential/PHF ☐

07 General Hospital ☐

08 Psych Hosp/ Age <21 ☐

09 Psych Hosp Age >64 ☐

12 Hospital Outpatient ☐

18 Non-Hospital Outpt. ☒

10 Requested Effective Date: To be completed by initiating Lead Manager after return of PFAR by CDAD. PFARs with "No Contract Action" status, enter the effective date services began and initial. PFARs with "Action Required" status, enter the effective date as indicated on DMH Summary of Amendment Changes/ DMH New Agreement Summary or the effective date services began (whichever is later) and initial.

Requested Effective Date 7/1/07-4/30/07 CS Lead Manager's Initials CS
 (This date may not reflect the SD/MC Requested Certification Date.
 See SD/MC Information Section, SD/MC Requested Certification Date Criteria.)

Operations Code

DMH _____, DHS _____, Other Public Agency _____,

Non-Governmental Agency X, Fee-For-Service _____,

Supervisory District 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 ☐

Mental Health Service Area 1 ☐ 2 ☐ 3 ☐ 4 ☒ 5 ☐ 6 ☐ 7 ☐ 8 ☐ CW ☐

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